Division of Mental Retardation Services

Resource Handbook
For the
Professional Support Services License

February 2003

Introduction

The information in this resource handbook is designed to support individuals and agencies in becoming providers of Professional Support Services (PSS) through the Tennessee Division of Mental Retardation Services. Any entity providing occupational therapy, physical therapy, speech language pathology, and/or nursing desiring to provide services through the Division of Mental Retardation (DMRS) must obtain a license to provide PSS through the Tennessee Department of Health (DOH) and must also be approved through the DMRS and have a formal Provider Agreement.

Section I contains a flowchart for individuals and agencies to follow in their pursuit of becoming a provider of PSS services through the DMRS. It is designed to be used as checklist to assure all necessary steps are completed. Components of this flowchart will be updated as needed for future potential providers.

Section II contains a copy of the Standards for Home Care Organizations Providing Professional Support Services rules, Chapter 1200-8-34 as set forth by the DOH. These rules officially take effect on April 9, 2003, at which time the DOH will begin the licensing process. Persons applying for a license to provide PSS need to meet each of the rule requirements. The DOH will complete an initial announced survey, prior to issuing a PSS license, which will incorporate a review of policies and procedures and personnel files.

Section III contains policy and procedure **samples**. These samples can be utilized for the development of policy and procedure manuals and personnel files as outlined in the Standards for Home Care Organizations Providing Professional Support Services rules, Chapter 1200-8-34 as set forth by the DOH. Individuals and agencies should keep in mind when utilizing the samples that they will need to review each one closely, referencing the rules, and modify it according to their situation. *The **bolded** information, at a minimum, needs to be personalized according to each potential provider's situation.*

Section I:

Steps for Applying to Provide Professional Support Services

Steps for Applying to Provide Professional Support Services

The following chart outlines the steps for obtaining a PSS license and can be utilized as a checklist to assure completion of all components. Approval to provide PSS services through DMRS is essentially a three-step process including:

1. Issuance of a Professional Support Services License through the Department of Health (DOH)
2. Approval of the DMRS Provider Application for Individual Professional Services *or* the DMRS Provider Application for Corporate Professional Services
3. Obtaining an approved TennCare/DMRS Provider Agreement in each region where services are to be provided

It is recommended that new potential providers contact the DMRS first, to discuss service provision prior to initiating this process, as there are non-refundable fees attached to the PSS License. See the following page for pertinent contact numbers.

Steps	Completed?
Contact the Department of Health (DOH) to obtain an application for a license to provide Professional Support Services (OT, PT, SLP, and Nursing services)	
Complete and return the application, along with the $800.00 fee, for the PSS license to the DOH ($200 fee if already licensed through the Division of Mental Health and Developmental Disabilities or if an approved Provider Agreement with DMRS was in place prior to January 1, 2003)	
After receiving and processing the PSS license application and fee, the DOH will send out a letter to the applicant indicating receipt of the application and fee and the need to contact the DOH Regional Office to schedule an initial survey, prior to the issuance of the PSS license	
Prior to the DOH survey the applicant must establish an administrator and have adequate policies and procedures in place in accordance with the: • Standards for Home Care Organizations Providing Professional Support Services rules and • Professionally recognized standards of practice The applicant will need to assure these policies and procedures take into account requirements set forth in the: • Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled and its rules • TennCare/DMRS Provider Agreement	
If not a current provider through DMRS, once the PSS license application process has been initiated, request and complete a DMRS Provider Application for Individual *or* Corporate Professional Services through the DMRS Central Office	
Once the DMRS application to provide services is approved, DMRS will send out a letter indicating whether or not the applicant is approved	
If approved, contact the DMRS Regional Office person responsible for processing TennCare/DMRS Provider Agreements as indicated in the approval letter (if approved in more than one region, separate TennCare/DMRS Provider Agreements are needed in each region)	

Complete the TennCare/DMRS Provider Agreement(s) and return to appropriate DMRS Regional Office(s) for approval/processing and assignment of agency number and site code	
Contact the DMRS Central Office and Provider Supports Unit at the Regional Office to schedule general orientation (this can be done while the above steps are being taken)	
Therapists and therapy agencies approved to provide services need to contact the Regional Physical Nutritional Management (PNM) Coordinator (as indicated in approval letter) to schedule orientation with the Regional PNM Team (this can be done while the above steps are being taken)	
Once the PSS License is issued, the TennCare/DMRS Provider Agreement is approved and signed, and the DMRS orientation has occurred, the agency number and site code are entered into the DMRS provider system and the provider can begin accepting referrals for services	

Department of Health, Health Care Facilities (Licensing Unit):
615-741-7221

Website address: http://www.state.tn.us/health/
To obtain an application online:
Click on Forms and Publications
Click on Health Care Facilities
Click on Application for Professional Support Services Provider License
(In the future providers will also be able to obtain the PSS License Rules and renew their application online)

DMRS Central Office contacts:

Susan Moss
Professional Services Applications
615-253-4632

Marlenia Overholt
Nursing
615-253-6095

Karen Wills
Statewide PNM (Therapy and Nutrition Services) Coordinator
615-532-3063

DMRS Regional Office contacts:

	West	Middle	East
Nursing Directors	Linda Sain 901-213-1800	Bernie McCarty 615-231-5445	Danny Ricker 423-787-6833
PNM Coordinators (Therapy and Nutrition)	Dawn Locke 901-213-1940	Libby Skeggs 615-231-5443	Jennifer Ottinger 423-798-6260

Section II:

Standards for Home Care Organizations Providing Professional Support Services Rules

Department of Health
Rulemaking Hearing Rules
Board for Licensing Health Care Facilities
Division of Health Care Facilities

Chapter 1200-8-34
Standards for Home Care Organizations Providing Professional Support Services

New Rules

Table of Contents

1200-8-34-.01 Definitions.

(1) Administrator. A person who establishes policies and procedures and is responsible for the activities of the agency and its staff. This person may be a physician, registered nurse, therapist, or a person with at least one (1) year experience in a health or disability related field. The administrator of a home care organization may serve as both a home health agency and professional support service agency administrator if both agencies are owned by the same corporation or legal entity.

(2) Advance Directive. A written statement such as a living will, a durable power of attorney for health care, or a do not resuscitate order relating to the provision of health care when the individual is incapacitated.

(3) Agency. A home care organization providing professional support services.

(4) Analysis. A process for identifying the most basic or causal factor or factors that underlie variation in performance leading to an unusual incident. The analysis must contain the following analytical processes: the proximate cause of the unusual incident, an analysis of systems and processes involved in the unusual incident, identification of possible common causes, identification of potential improvements, the plan of correction or action plan, and measures of effectiveness.

(5) Board. The Tennessee Board for Licensing Health Care Facilities.

(6) Clinical Note. A written and dated notation containing a consumer assessment, responses to medications, treatments, services, any changes in condition and signed by a health team member who made contact with the consumer.

(7) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(8) Competent. A consumer who has decision-making capability.

(9) Comprehensive Nursing assessment. An assessment conducted by a registered nurse which consists of four parts: completion of a Physical Status Review (PSR); consumer and family history; identification of health concerns, functional abilities, activities of daily living; and, completion of a head to toe physical assessment.

(10) Consumer. Any person with a primary diagnosis of mental retardation or developmental disability served through the Division of Mental Retardation or the Department of Mental Health and Developmental Disabilities in need on nursing, occupational, physical or speech therapy through a professional support service agency.

(11) Corrective Action Plan/Report. A report filed to the department by the agency after reporting an unusual event. The report must consist of the following:

(a) the action(s) implemented to prevent the reoccurrence of the unusual incident,

(b) the time frames for the action to be implemented,

(c) the person(s) designated to implement and monitor the action, and

(d) the strategies for the measurements of effectiveness to be established.

(12) Department. The Tennessee Department of Health.

(13) Hazardous Waste. Materials whose handling, use, storage and disposal are governed by local, state or federal regulations.

(14) Individual Support Plan (ISP). The document resulting from a process of person-centered planning. The ISP describes in detail the person, including his/her vision for his/her future, preferences, non-negotiables, and other information required to support the person in daily life. The ISP contains outcomes to be achieved with the assistance of the person's

Circle of Support that relate to the person's vision for the future. The ISP is written upon a person's enrollment in Department of Mental Retardation Services and updated thereafter as changes occur in the individual's life, or at least annually.

(15) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(16) Legal Guardian. Any person authorized to act for the patient pursuant to any provision of T.C.A. Title 34, Chapters 5 and 11 through 13.

(17) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(18) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(19) Life Threatening or Serious Injury. Injury requiring the consumer to undergo significant additional diagnostic or treatment measures.

(20) Medical Record. Medical histories, records, reports, clinical notes, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries and other written electronic, or graphic data prepared, kept, made or maintained in an agency that pertains to confinement or services rendered to consumers. The medical record shall meet the standards established in the contractual agreement between the state agency financially responsible for services to individuals with mental retardation or developmental disabilities.

(21) Occupational Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(22) Occupational Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(23) Patient/Consumer Abuse. Patient/consumer neglect, intentional infliction of pain, injury, or mental anguish. Patient/consumer abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or consumer; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient/consumer abuse" for purposes of these rules.

(24) Physical Status Report (PSR). An instrument used by a registered nurse or other designated professional staff to determine level of risk and define the required health services and supports.

(25) Physical Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(25) Physical Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(26) Physician. A person currently licensed as such by the Tennessee Board of Medical Examinations or currently licensed by the Tennessee Board of Osteopathic Examination.

(27) Plan of Care. Health care plan resulting from the comprehensive nursing assessment and/or therapy plan identifying the need for nursing, physical, occupational, or speech therapy for consumer's of professional support services. The plan meets the standards established in contractual agreement between the state agency financially responsible for services to individuals with mental retardation or developmental disabilities.

(28) Professional Support Services. Nursing, occupational, physical or speech therapy services provided to individuals with mental retardation or developmental disabilities pursuant to a contract with the state agency financially responsible for such services.

(29) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(30) Shall or Must. Compliance is mandatory.

(31) Site Code. An approved location from which the professional support services may be provided as deemed by the Department of Mental Retardation Services with written notice provided to the Department of Health by the professional support service agency for each site code approved for such agency.

(32) Speech Language Pathologist. A person currently licensed as such by The Tennessee Board of Communication Disorders and Sciences or, for purposes of these rules, a Speech Language Pathologist who is currently in their Clinical Fellowship Year.

(33) Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Periodic supervision must be provided if the person is not a licensed or certified assistant, unless otherwise provided in accordance with these rules.

(34) Unusual Event. The abuse of a consumer or an unexpected occurrence or accident that results in death, life threatening or serious injury to a consumer that is not related to a natural course of the consumer's illness or underlying condition.

(35) Unusual Event Report. A report form designated by the department to be used for reporting an unusual event.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, and 68-11-209.

1200-8-34-.02 Licensing Procedures.

(1) No person, partnership, association, corporation, or state, county, or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate or maintain in the State of Tennessee any home care organization providing professional support services without having a license. A license shall be issued to the person or persons named and for the premises listed in the application for licensure. The name of the agency shall not be changed without first notifying the department in writing. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the agency.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the department.

(b) Each new applicant for a license, who has not previously been licensed by the Department of Mental Health and Developmental Disabilities (DMHDD) to provide a service to individuals with mental retardation or other developmental disabilities, shall pay an annual license fee in the amount of eight hundred dollars ($800.00). Home Care Organizations or individuals who are currently licensed by DMHDD to provide professional support services pursuant to T.C.A. 68-11-201(17)(D)(i-ii)(a-d), shall pay a fee to the Department of Health of two hundred dollars ($200.00). The fee must be submitted with the application and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Consumers shall not be admitted to the agency until a license has been issued. Applicants shall not hold themselves out to the public as being an agency until the license has been issued. A license shall not be issued until the agency is in substantial compliance with these rules, including submission of all information required by T.C.A. §68-11-206(1) or as later amended, and all information required by the Commissioner.

(d) The applicant must prove the ability to meet the financial needs of the agency providing professional support services.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party

when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(3) A proposed change of ownership must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(a) For the purposes of licensing, the licensee of an agency has the ultimate responsibility for the operation of the agency, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the agency's operation is transferred.

(b) Circumstances constituting a change of ownership may include, but are not limited to, the following:

1. Partnership. In the case of a partnership, the removal, addition, or substitution of a partner constitutes a change of ownership. If the agency is owned by a limited partnership, the removal of the general partner or general partners constitutes a change of ownership.

2. Corporation. The merger of an agency owner into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock (even when a controlling interest), or the merger of another corporation into the originally-licensed corporation does not constitute a change of ownership.

3. Leasing. The lease of an agency's operations constitutes a change of ownership. Sale/lease -back agreements shall not be treated as changes of ownership if the lease involved the agency's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the exact same legal form as the former owner.

4. Transfers. Transfer of an agency's legal title, or a transfer between levels of government constitutes a change of ownership. A transfer between departments of the same level of government does not constitute a change of ownership.

5. Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the agency. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(4) To be eligible for a license or renewal of a license, each agency shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction shall be established and submitted to the Department.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

1200-8-34-.03 Disciplinary Procedures.

(1) The Board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the agency or the patient's home;

(d) Conduct or practice found by the Board to be detrimental to the health, safety, or welfare of the consumers of the agency; or

(e) Failure to renew the license.

(2) The Board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the consumer of the agency;

(c) The conduct of the agency in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(d) Any prior violations by the agency of statutes, rules or orders of the Board.

(3) Inappropriate transfers are prohibited and violation of the transfer provisions shall be deemed sufficient grounds to suspend or revoke an agency's license.

(4) When an agency is found by the Department to have committed a violation of this chapter, the Department will issue to the agency a statement of deficiencies. Within ten (10) days of receipt of the statement of deficiencies the agency must return a plan of correction indicating the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(c) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(5) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the agency's license to possible disciplinary action.

(6) Any licensee or applicant for a license, aggrieved by a decision or action of the department or Board, pursuant to this chapter, may request a hearing before the Board. The proceedings and judicial review of the Board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§4-5-101, et seq.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.

1200-8-34-.04 Administration.

(1) The home care organization providing professional support services must organize, manage and administer its services to attain and maintain the highest practicable functional capacity for each consumer regarding nursing and therapy needs as indicated by the plan of care.

(2) The agency develops and maintains administrative control of any site code.

(3) The organizational structure, professional support services provided, administrative control and lines of authority for the delegation of responsibility down to the consumer care level shall be clearly set forth in writing and shall be readily identifiable. Administrative and supervisory functions shall not be delegated to another agency.

(4) A governing body (or designated person(s) so functioning) must: assume full legal authority and responsibility for the management and provision of all professional support services; fiscal operations; quality assessment and performance improvement programs. The governing body shall appoint a qualified administrator who is responsible for the day-to-day operation of the organization and is responsible for designating people to carry out these functions.

(5) The administrator shall organize and direct the organization's ongoing functions, the professional personnel and the staff; employ qualified personnel and ensure adequate staff education and evaluation for all personnel involved in direct care; ensure the accuracy of public

information materials and activities; and implement an effective budgeting and accounting system. A person with sufficient experience and training shall be authorized in writing to assume temporary duty during the administrator's short-term absence. The agency shall have written policies and procedures describing organizational structures including line of authority, responsibilities, accountability and supervision of personnel. All agencies shall have a designated person or governing body that establishes policy and is responsible for the activities of the agency and its staff. The designee may be a physician, registered nurse, or a therapist.

(6) An agency shall have a duly qualified administrator accessible during normal operating hours. Any change of administrators shall be reported to the Department within fifteen (15) days.

(7) The administrator of a home care organization may serve as both a home health agency and professional support service agency administrator if both agencies are owned by the same corporation or legal entity.

(8) The agency shall maintain an office with a working telephone that is staffed or takes voice messages during normal business hours.

(9) When licensure is applicable for a particular position of employment, a copy of the current license or the number and renewal number of the employee's current license must be maintained in the employee's personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Proof of adequate medical screenings to exclude communicable disease shall be maintained in the file of each employee.

(10) Personnel practices shall be supported by written personnel policies. Personnel records shall include at a minimum: job descriptions, verification of references and credentials, and performance evaluations. Personnel records must be kept current. Professional Support service agencies employing only one (1) staff member must maintain a personnel record with verification of current credentials.

(11) An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the organization's personnel engaged in delivery of professional support services. Each employee shall receive appropriate orientation to the organization, its policies, the employee's position, and the employee's duties. Records shall be maintained which indicate the subject of and attendance at such staff development programs.

(12) If personnel, under hourly or per visit contracts, are utilized by the agency, there shall be a written contract between such personnel and the agency clearly designating:

(a) That consumers are accepted for care only by the agency;

(b) Which professional support services are to be provided;

(c) That it is necessary to conform to all applicable organization policies including personnel qualifications;

(d) The responsibility for participating in developing plans of care;

(e) The manner in which professional support services will be controlled, coordinated and evaluated by the agency;

(f) The procedures for submitting clinical and progress notes, scheduling visits and periodic patient evaluations; and

(g) The procedures for determining charges and reimbursement.

(13) Supervision of licensed personnel must occur at a minimum of every thirty (30) days and must include direct observation of the provision of care, record review and individual conferences.

(14) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. An agency which violates a required policy also violates the rule establishing the requirement.

(14) Policies and procedures shall be consistent with professionally recognized standards of practice.

(15) All agencies shall adopt appropriate policies regarding the testing of consumers and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(16) No agency shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the Board, the Department, the Department of Human Services Adult Protective Services or the Comptroller of the State Treasury. An agency shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation with them or because a person is subpoenaed to testify at a hearing involving one of these authorities.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.

1200-8-34-.05 Admissions, Discharges, and Transfers.

(1) Consumers shall be accepted to receive professional support services on the basis of a reasonable expectation that the consumer's nursing and therapy needs can be met adequately by the agency.

(2) Professional support services shall be provided as prescribed by the attending physician. The plan for providing professional support services and the expected outcomes shall be incorporated into the consumer's plan of care or individual support plan.

(3) The agency staff shall determine if the consumer's needs can be met by the agency's services and capabilities.

(4) Every person admitted for professional support services by any agency covered by these rules shall be provided as prescribed by the consumer's physician, as defined in this chapter, who holds a license in good standing. The name of the patient's attending physician shall be recorded in the patient's medical record.

(5) The agency staff shall obtain the consumer or his/her designee's written consent for professional support services.

(6) The signed consent form shall be included with the consumer's individual clinical record.

(7) A diagnosis must be entered in the admission records of the agency for every person admitted for care or treatment.

(8) No medication or treatment shall be provided to any patient of an agency except on the order of a physician lawfully authorized to give such an order.

(9) A medical record shall be developed and maintained for each consumer admitted.

(10) The agency's discharge planning process, including discharge policies and procedures, must be in writing and follow the guidelines established in the written agreement between the agency and the Division of Mental Retardation Services (DMRS). If the agency determines that they are no longer willing or able to provide services, they must comply with the following:

(a) Prior to discontinuation of authorized services, the agency will obtain approval from the DMRS;

(b) The agency will notify the consumer, their conservator or guardian, the support coordinator, and DMRS no less than sixty (60) days prior to the planned discharge;

(c) If the consumer or his/her representative request a hearing in accordance with T.C.A. 33-1-202, the discharge will not occur prior to the final agency decision and resolution of the administrative appeal unless ordered by a court and approved by the state;

(d) The agency shall continue to provide services until the consumer is provided with other services that are of acceptable and appropriate quality in order to maintain continuity of care;

(e) If the consumer or his/her representative request to be discharged from the agency, the agency will follow the steps as outlined above and provide transfer documentation to new provider, if requested, in order to maintain continuity of care and facilitate transfer.

(12) The agency shall ensure that no person on the grounds of race, color, national origin or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the agency. The agency shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.

1200-8-34-.06 Basic Agency Functions.

(1) All personnel providing professional support services shall assure that their efforts effectively complement other services provided to the consumer, are functionally integrated into the individual daily routine and support the outcome outlined in the individual support plan. A written report of progress shall be provided to the consumer's support coordinator/case manager monthly. A written summary report for each patient shall be sent to the attending physician at least annually.

(2) Plan of Care.

(a) The written plan of care, developed in consultation with the organization staff, shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of services, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a consumer under a plan of care which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for professional support services shall include the specific treatment or modalities to be used and their amount, frequency and duration. The therapist and other organization personnel shall participate in developing the plan of care.

(b) The plan(s) of care for acute or episodic illness shall be reviewed by the attending physician and agency personnel involved in the consumer's care as often as the severity of the patient's condition requires, but at least annually. Plans of care resulting from

Comprehensive Nursing Assessment will be reviewed in accordance with the physical status review schedule. Evidence of review by the physician must include the physician's signature and date of the review on the plan of care. A facsimile of the physician's signature is acceptable. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

(3) Drugs and treatments shall be administered by appropriately licensed agency personnel, acting within the scope of their licenses. Orders for drugs and treatments shall be signed and dated by the physician.

(4) Skilled Nursing Services.

(a) When skilled nursing is provided, the services shall be provided by or under the supervision of a registered nurse who has no current disciplinary action against his/her license, in accordance with the plan of care. This person shall be available at all times during operating hours and participate in all activities relevant to the professional support services provided, including the development of qualifications and assignment of personnel.

(b) The registered nurse's duties shall include but are not limited to the following: make the initial evaluation visit, except in those circumstances where the physician has ordered therapy services as the only skilled service; regularly evaluate the patient's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the physician and other personnel of changes in the patient's condition and needs; counsel the patient and family in meeting nursing and related needs; participate in in-service programs; supervise and teach other nursing personnel. The registered nurse or appropriate agency staff shall initially and periodically evaluate drug interactions, duplicative drug therapy and non-compliance to drug therapy.

(c) The licensed practical nurse shall provide services in accordance with agency policies, which may include but are not limited to the following: prepare clinical and progress notes; assist the physician and/or registered nurse in performing specialized procedures; prepare equipment and materials for treatments; observe aseptic technique as required; and assist the patient in learning appropriate self-care techniques.

(5) Therapy Services.

(a) All therapy services offered by the agency directly or under arrangement shall be planned, delegated, supervised or provided by a qualified therapist in accordance with the plan of care. A

qualified therapist assistant may provide therapy services under the supervision of a qualified therapist in accordance with the plan of care. The therapist shall assist the physician in evaluating the level of function, helping develop the plan of care (revising as necessary), preparing clinical and progress notes, advising and consulting with the family and other agency personnel, and participating in in-service programs.

(b) Speech therapy services shall be provided only by a licensed speech language pathologist in good standing or therapist in the Clinical Fellowship Year under the supervision of a speech language pathologist.

(6) Performance Improvement.

(a) An agency shall have a committee or mechanism in place to review, at least annually, past and present professional support services including contract services, in accordance with a written plan, to determine their appropriateness and effectiveness and to ascertain that professional policies are followed in providing these services.

(b) The objectives of the review committee shall be:

1. To assist the agency in using its personnel and facilities to meet individual and community needs;

2. To identify and correct deficiencies which undermine quality of care and lead to waste of agency and personnel resources;

3. To help the agency make critical judgments regarding the quality and quantity of its services through self-examination;

4. To provide opportunities to evaluate the effectiveness of agency policies and when necessary make recommendations to the administration as to controls or changes needed to assure high standards of patient care;

5. To augment in-service staff education, when applicable;

6. To provide data needed to satisfy state licensure and certification requirements;

7. To establish criteria to measure the effectiveness and efficiency of the professional support services provided to consumers; and

8. To develop a record review system for the agency to evaluate the necessity or appropriateness of the

professional support services provided and their effectiveness and efficiency.

(7) Infection Control.

(a) There must be an active performance improvement program for developing guidelines, policies, procedures and techniques for the prevention, control and investigation of infections and communicable diseases.

(b) Formal provisions must be developed to educate and orient all appropriate personnel and/or family members in the practice of aseptic techniques such as handwashing and scrubbing practices, proper hygiene, use of personal protective equipment, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of consumer care equipment and supplies.

(c) Continuing education shall be provided for all agency consumer care providers on the cause, effect, transmission, prevention and elimination of infections, as evidenced by the ability to verbalize/or demonstrate an understanding of basic techniques.

(d) The agency shall develop policies and procedures for testing a consumer's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the agency, a student studying at the agency or other health care provider rendering services at the agency is exposed to a consumer's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(e) The agency and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV and communicable diseases.

(f) Precautions shall be taken to prevent the contamination of sterile and clean supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents.

(8) Medical Records.

(a) A medical record containing past and current findings in accordance with accepted professional standards shall be maintained for every consumer receiving professional support services. In addition to the plan of care, the record shall contain: appropriate identifying information; name of physician; all medications and treatments; signed and dated clinical notes. Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.

(b) All medical records, either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of consumers under mental disability or minority, their complete agency records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the consumer, whichever is longer. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the agency's policies and procedures, and no record may be destroyed on an individual basis.

(c) Even if the agency discontinues operations, records shall be maintained as mandated by this chapter and the Tennessee Medical Records Act (T.C.A. §§ 68-11-308). If a consumer is transferred to another health care facility or agency, a copy of the record or an abstract shall accompany the consumer when the agency is directly involved in the transfer.

(d) Medical records information shall be safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. The consumer's written consent shall be required for release of information when the release is not otherwise authorized by law.

(e) For purposes of this rule, the requirements for signature or countersignature by a physician or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established protocol or rules.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-11-304.

1200-8-34-.07 Reserved.

1200-8-34-.08 Reserved.

1200-8-34-.09 Reserved.

1200-8-34-.10 Infectious and Hazardous Waste.

(1) Each agency must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous waste. These policies and procedures must comply with

the standards of this rule and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste human blood and blood products such as serum, plasma, and other blood components;

(b) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in patient care; and

(c) Other waste determined to be infectious by the agency in its written policy.

(3) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid and puncture-resistant containers which must then be tightly sealed.

(b) Infectious and hazardous waste must be secured in fastened plastic bags before placement in a garbage can with other household waste.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(4) After packaging, waste must be handled, transported and stored by methods ensuring containment and preserving of the integrity of the packaging, including the use of secondary containment where necessary.

(5) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons. Waste must be stored in a manner and location which affords protection from animals, precipitation, wind and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.

(6) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the agency must ensure that proper actions are immediately taken to:

(a) Isolate the area;

(b) Repackage all spilled waste and contaminated debris in accordance with the requirements of this rule; and,

(c) Sanitize all contaminated equipment and surfaces appropriately.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.

1200-8-34-.11 Records and Reports.

(1) The agency shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. They shall be maintained in a single file and shall be made available for inspection during normal business hours to any person who requests to view them:

(a) Department licensure and fire safety inspections and surveys;

(b) Centers for Medicare and Medicaid Services (CMS) surveys and inspections, if any;

(c) Orders of the Commissioner or Board, if any; and

(d) Comptroller of the Treasury's audit report and finding, if any.

(2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a consumer or an unexpected occurrence or accident that results in death, life threatening or serious injury to a consumer.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a consumer, not related to a natural course of the consumer's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

1. medication errors that result in permanent consumer injury, a near death event, or a death;

2. aspiration in a non-intubated consumer related to conscious/moderate sedation;

3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

4. volume overload leading to pulmonary edema;

5. blood transfusion reactions, resulting in death or use of wrong type of blood and/or delivery of blood to the wrong consumer;

6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness or death;

7. burns of a second or third degree;

8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

    (i) procedure related injury requiring repair or removal of an organ;

    (ii) hemorrhage that results in serious injury or death;

    (iii) displacement, migration or breakage of an implant, device, graft or drain;

    (iv) post operative wound infection following clean or clean/contaminated case;

    (v) any unexpected operation or reoperation related to the primary procedure;

    (vi) hysterectomy in a pregnant woman;

    (vii) ruptured uterus;

    (viii) circumcision requiring repair;

    (ix) incorrect procedure or incorrect treatment that is invasive;

    (x) wrong patient/wrong site surgical procedure;

    (xi) unintentionally retained foreign body;

(xii) loss of limb or organ, impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;

(xiii) criminal acts;

(xiv) suicide or attempted suicide;

(xv) elopement from the facility;

(xvi) infant abduction, or infant discharged to the wrong family;
(xvii) adult abduction;

(xviii) rape;

(xix) consumer altercation;

(xx) abuse, neglect, or misappropriation of consumer funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

1. strike by the staff at the facility;

2. external disaster impacting the facility;

3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

4. fires at the facility which disrupt the provision of consumer care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(c) For health services provided in a “home” setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department’s approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or casual factor(s) that underlie variation in performance leading to the unusual event by (a) determining

the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

(f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

(h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate

governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

(j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the incident by the facility.

(k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of incidents reported by facilities to the Department for the preceding calendar year.

(l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-207, 68-11-209, 68-11-210, and 68-11-213.

1200-8-34-.12 Consumer Rights.

(1) Each consumer has at least the following rights:

(a) To privacy in treatment and personal care;

(b) To have appropriate assessment and management of pain.

(c) To be involved in the decision making and all aspects of their care.

(d) To be free from mental and physical abuse. Should this right be violated, the agency must notify the Department within five (5) business days and the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. §71-6-101 et seq.;

(d) To refuse treatment. The consumer must be informed of the consequences of that decision, and the refusal and its reason must be reported to the physician and documented in the medical record;

(h) To refuse experimental treatment and drugs. The consumer's written consent for participation in research must be obtained and retained in his or her medical record; and

(g) To have his or her records kept confidential and private. Written consent by the consumer must be obtained prior to release of information except to persons authorized by law. If the consumer is mentally incompetent, written consent is required from the consumer's legal representative. The agency must have policies to govern access and duplication of the consumer's record.

(2) Each consumer has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.

1200-8-34-.13 Reserved.

1200-8-34-.14 Reserved.

Section Three:

Policy and Procedure Samples for the Professional Support Services License

Index of Policy and Procedure Samples

1200-8-34-.02 Licensing Procedures

A. Policy
The agency will adhere to the Professional Support Services (PSS) licensing procedures as set forth by the Department of Health.

B. Objectives
1. To assure the application process for obtaining a PSS license is completed and a license is issued prior to the agency taking any referrals for consumers.
2. To outline the process for making any changes that affect the license.
3. To outline the process for adhering to disciplinary procedures, when applicable, based on findings of periodic inspections for compliance to the rules.

C. Procedure
1. The agency will not take on any referrals for consumers until the Department of Health issues a PSS license.
2. The PSS license will be conspicuously posted at the agency address listed on the application/license.
3. The applicant will prove it can meet the financial needs of the agency providing PSS.
4. A proposed change of ownership, as defined in the rules under 1200-8-34-.02 (3), will be reported to the department a minimum of 30 days prior to the change and a new application and fee will be submitted so that a new license can be issued upon approval.
5. A change in agency name will be reported to the department in writing prior to the change occurring.
6. The license will not be transferred or assigned.
7. The agency will renew the license annually prior to June 30th.
8. The agency will comply with the requirement of periodic inspections when contacted by the department.
9. If deficiencies are noted, the agency will respond with a plan of correction within ten (10) days of the receipt of the statement of deficiencies indicating the following:
    a. How the deficiencies will be corrected
    b. The date upon which each deficiency will be corrected
    c. The measures that will be put in place to ensure that the deficient practice does not recur.
    d. How the corrective action plan will be monitored to ensure that the deficient practice does not recur.

1200-8-34-.04 Administration
(3-5) Organizational Structure

A. Policy:
The governing body of the agency will establish the organizational structure within the agency. Staff hired will adhere to the lines of authority in carrying out specified responsibilities as outlined in specific job descriptions and the organizational structure.

B. Objectives
1. To outline the organizational structure and lines of authority within the agency.

2. To define the responsibilities of personnel within the agency.

3. To denote accountability and supervision of personnel within the agency.

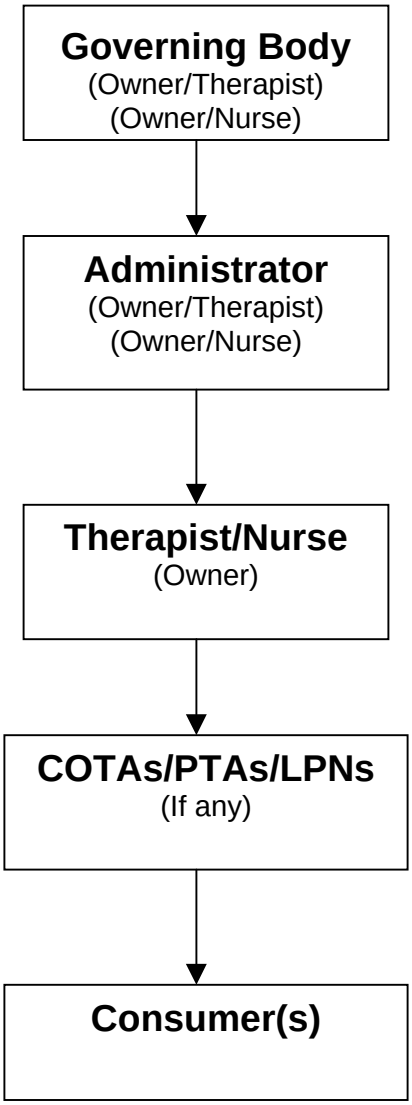
C. Definitions
Governing body: person within an agency assuming full legal authority and responsibility for the management and provision of all professional support services, fiscal operations, quality assessment, and performance improvement plans.

Administrator: A person who establishes policies and procedures and is responsible for the activities of the agency and its staff. This person may be a physician, registered nurse, therapist, or a person with at least one-year experience in a health or disability related field.

D. Procedure
1. A chart of the agency's organizational structure, denoting lines of authority, is *attached.*
2. *The administrator establishes policies and procedures, oversees the day to day activities of the agency* ***and its staff***, and is available via a telephone/pager system during normal working hours ***8:00am-4:30pm, Monday through Friday****.*
3. The administrator will authorize, in writing, a person within the agency with sufficient experience and training to assume temporary duty during his or her short-term absences. ***(An independent therapist or nurse will incorporate a written plan into their policies and procedures as to how duties and responsibilities will be carried out in their absence)***
4. Any change of administrator shall be reported to the Department of Health within fifteen (15) days.
5. ***The registered occupational therapists and physical therapists provide assessments and direct services for consumers. They may supervise therapy assistants in accordance with their professional state rules regarding supervision (General Rules Governing the Practice of Occupational Therapy, Chapter 1150-2 and General Rules Governing the Practice of Physical Therapy, Chapter 1150-1). Registered nurses may utilize LPN's and will supervise them in accordance with their professional state rules (Rules and Regulations of Registered Nurses, Chapter 1000-1 and Rules and Regulations of Licensed Practical Nurses, Chapter 1000-2)***
6. Refer to specific job descriptions for responsibilities of each position.

(SAMPLE)

Agency's Chart of Organizational Structure



1200-8-34-.04 Administration
(9-10) Personnel Records

A. Policy
The agency will maintain confidential personnel records that are subject to review during both Department of Health and Division of Mental Retardation Services surveys.

B. Objective
To identify the documents to be maintained in the personnel records.

C. Procedure
1. Personnel records shall be kept on all employees and contracted staff for the agency.
2. Personnel records shall be maintained in a confidential manner and overseen by the agency administrator.
3. Personnel records shall include at a minimum:
    - Job description
    - Verification of references and credentials including education, training, experience, and personnel background
    - Professional license (if applicable)
    - Performance evaluations
    - Evidence of required training
    - Evidence of related continuing education
    - Proof of adequate medical screening
4. Personnel shall have access to their file when requested.

1200-8-34-.04 Administration
(10) Performance Evaluation

[Include this policy if the agency has any employees/contract staff in addition to the administrator/owner]

A. Policy
A formal written performance evaluation will be conducted annually on all staff members.

B. Objectives
1. To ensure that an employee understands the responsibilities of his or her position.
2. To ensure that an employee can satisfactorily fulfill the demands of a position.
3. To facilitate communication between the employee and their supervisor in an effort to promote more effective job performance.
4. To identify performance problems.
5. To improve the performance of an employee.

C. Procedure
1. ***The Performance Plan and Review process is a three-step process: a.) establishment of mutually agreed upon annual goals and objectives; b.) interim review of objectives; and c.) annual performance plan and review. This process requires the active participation of both the supervisor and the staff member.***
2. ***The administrator is responsible for maintaining or delegating to supervisors the responsibility of maintaining a schedule for the Performance Plan and Review process for each staff member.***
3. During orientation to the agency, each staff member shall receive appropriate orientation to the agency, including the staff's job responsibilities as outlined in the job description. Documentation of this orientation must be signed and filed in the personnel record.
4. ***At the onset of employment, the supervisor will schedule a time to produce a performance plan together with the new employee.***
5. ***The performance-planning meeting shall be documented indicating the attendance of the staff and supervisor. This documentation as well as a formal performance plan will be signed and dated by both the supervisor and the staff member and filed in the personnel record.***
6. ***The following steps are to be taken in order to complete the Performance Plan and Review process:***
    - ***Performance plan (measurable annual goals and objectives) developed based on job responsibilities***
    - ***Establish the priorities of the duties***
    - ***Identify the standards upon which performance will be measured for each of the duties identified***
    - ***Interim reviews (a minimum of two per year will be held between the supervisor and staff with more frequency as indicated if problems arise) to discuss progress of goals and objectives and for supervisor to note any problems and develop a plan of action for improvement (also a time for staff to indicate needs for more support in particular areas)***

- ***Annual performance plan and review***

7. ***Once the Performance Plan and Review process has been completed, the documents will be signed by both the supervisor and staff member to indicate it has been fully discussed (the staff member's signature does not indicate agreement with the evaluation, only that the formal discussion has taken place). The staff member will have the opportunity to make comments in response to the performance review on the document itself or as an attached document.***
8. A final signed copy of the performance evaluation will be kept on file in the personnel record.
9. ***Newly employed staff members will have a probationary evaluation after three months of employment.***

(SAMPLE)

Job Description

Agency: ***(Agency Name)***

Job Title: ***Administrator***

Position Summary: A person who establishes policies and procedures and is responsible for the activities of the agency and its staff. This person may be a physician, registered nurse, therapist, or a person with at least one-year experience in a health or disability related field.

Principle Duties and Responsibilities:

1. Maintains open communication with the Division of Mental Retardation Services (DMRS), Independent Support Coordination agencies and other related provider agencies. Identifies and works to resolve problems as they arise.
2. Maintains knowledge of the standards for the DMRS quality enhancement survey and the Department of Health survey and coordinates preparation for these surveys.
3. Maintains working knowledge of the DMRS Provider Agreement requirements, the Standards for Home Care Organizations Providing Professional Support Services rules, agency policies and operating procedures.
4. Develops and monitors/oversees compliance with agency policies and procedures.
5. Assures all staff are in compliance with maintaining professional licenses and training requirements.
6. ***Provides oversight, education, and training to agency staff.***
7. ***Participates in and provides relevant training for staff to improve skills and knowledge in the area of providing supports and services for persons with mental retardation and developmental disabilities.***
8. Maintains and updates confidential personnel files.
9. Ensures confidentiality and maintenance of consumer files including the assurance of staff completing appropriate documentation as outlined in medical record policy.
10. ***Exhibits a high degree of responsibility for confidential manners.***
11. Oversees the agency operating budget.
12. ***Assumes other related responsibilities as required*.**

Position Requirements: This person may be a physician, registered nurse, therapist, or a person with a degree and at least one year experience in a health or disability related field. ***Clinical experience in the area of mental retardation and developmental disabilities a plus. Excellent interpersonal skills, including the ability to communicate professionally, both verbally and in writing. Willingness to maintain a flexible work schedule as needed.***

(SAMPLE)

Staff Performance Plan

Agency Name: **Staff Name:** **Date Plan Developed:**

1.	Aspect of Performance:	Performance standards: 1. 2. 3. 4. 5.
2.	Aspect of Performance:	Performance standards: 1. 2. 3. 4. 5.
4.	Aspect of Performance:	Performance standards: 1. 2. 3. 4. 5.
5.	Aspect of Performance:	Performance standards: 1. 2. 3. 4. 5.
6.	Aspect of Performance:	Performance standards: 1. 2. 3. 4. 5.

Staff Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

Review of Administrator (if different from supervisor):

Signature:_____ Date:_____

(SAMPLE)

Staff Performance Evaluation

Agency Name:

Date of Evaluation:

Staff Name:

No.	Aspect of Performance	Performance Level	Comments	Action(s)	Outcomes

Performance Levels:

Below Standards – staff performance does not meet expected outcome
Meets Standards – staff performance meets expected outcomes
Exceeds Standards – staff performance exceeds expected outcomes

Actions:

R – review of expectations
E – education/training needed
T – technical assistance needed
J – job observation by supervisor
O – other (to be specified)

Outcomes of Actions:

S – satisfactory performance
P – progressive discipline process
R – resignation
T – termination

Staff Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

Review of Administrator (if different from supervisor):

Signature:_____ Date:_____

1200-8-34-.04 Administration
(11) Training and Continuing Education

A. Policy
An ongoing educational program shall be planned and conducted for the development and improvement of skills of all agency personnel engaged in the delivery of professional support services

B. Objectives
1. ***(If there are agency staff)*** To ensure adequate orientation of new staff to the agency and the interrelated systems, policies and procedures, and the employee's job responsibilities.
2. ***(If there are agency staff)*** To support staff in developing the skills necessary to work within the field of mental retardation and developmental disabilities, increasing their level of competence, and increasing their productivity.
3. To meet required training standards set forth by the Division of Mental Retardation Services (DMRS).

C. Procedures
1. ***(If there are agency staff)*** Each new staff member will be formally oriented to the agency and its related systems (DMRS). This orientation will be documented and filed in the staff's personnel record.
2. The agency will assure that required DMRS training is scheduled and completed within specified time frames.
3. Documentation of all training and/or continuing education will be completed and filed in the ***staff person's*** personnel record.
4. Persons providing professional support services will be encouraged to cultivate their job by taking advantage of training and continuing education courses through DMRS, professional associations and agencies, university classes, and other related resources that demonstrate ***both the supervisor's and the staff member's*** commitment to continuous skill development.

(SAMPLE)

Agency Orientation Checklist

Employee Name: **Date Initiated:**

Supervisor Name: **Date Completed:**

Area of review	Date Reviewed	Able to perform (as applicable)	Employee Initials	Supervisor Initials	Comments
General Orientation					
Policies and Procedures					
DMRS Incident Reporting and Notification Operating Guideline 4.02					
DOH Unusual Event Reporting 1200-8-34-.11 (2)					
Other DMRS and PSS policies					
Documentation					
Training					
Abuse and neglect					
ISP					
Crisis pager					
Infection control					
Performance Evaluation Process					
Job description					
Other					
Orientation to Community Developmental Nursing/Best Practice Guidelines (for RNs providing Comprehensive Nursing Assessments)					
Therapy and Nutrition Services Guidelines					

Staff Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

<u>Review of Administrator</u> (if different from supervisor):

Signature:_____ Date:_____

1200-8-34-.04 Administration
(12) Contracted Services

A. Policy
If personnel, under hourly or per visit contracts, are utilized by the agency, there shall be a written contract between such personnel and the agency.

B. Objectives
1. To ensure that contracted staff complies with agency standards.
2. To outline the requirements and responsibilities of contracted staff.

C. Procedure
1. ***(If there are contracted staff)*** Contracted staff will be formally oriented to the agency and its related systems, policies and procedures, and job responsibilities. This orientation will be documented and filed in the personnel record.
2. The written contact will clearly designate the following information at a minimum:
    - That consumers are accepted for care only by the agency
    - Which professional support services are to be provided
    - That it is necessary to conform to all applicable organization policies including personnel qualifications
    - The responsibility for participating in developing plans of care
    - The manner in which professional support services will be controlled, coordinated, and evaluated by the agency
    - The procedures for submitting clinical and progress notes (and other documentation), scheduling visits and periodic evaluations
    - The procedures for submitting billing
3. Contracted staff is subject to the performance evaluation process as are any other agency staff.

1200-8-34-.04 Administration

(13) Supervision of Licensed Practical Nurses, Licensed Therapy Assistants, and Speech Language Pathologists in their Clinical Fellowship Year

(Applicable only if COTAs, PTAs, LPNs, or SLP CFYs are utilized by an agency)

A. Policy
Licensed therapy assistants, licensed practical nurses, and speech language pathologists (SLP) in their clinical fellowship year (CFY) will receive direct supervision.

B. Objectives
1. To ensure that the services delivered by licensed therapy assistants, licensed practical nurses, and SLPs in their CFY meet required state and national standards, policies and procedures.
2. To ensure that licensed therapy assistants and licensed practical nurses are following the designated plans of care and are utilizing appropriate decision making skills that is within their professional scope of practice.
3. To ensure that licensed therapy assistants, licensed practical nurses, and SLPs in their CFY are provided with support for their ongoing professional growth.

C. Procedure
1. Supervision of licensed practical nurses is to occur at a minimum of every thirty (30) days and must include direct observation of the provision of care, record review, and individual conferences.
2. Licensed occupational therapy assistants are to be supervised in accordance with the General Rules Governing The Practice of Occupational Therapy, Chapter 1150-2 and the American Occupational Therapy Association's *Guide for Supervision of Occupational Therapy Personnel in the Delivery of Occupational Therapy Services*.
3. Licensed physical therapy assistants are to be supervised in accordance with the General Rules Governing The Practice of Physical Therapy, Chapter 1150-1.
4. Speech Language Pathologists in their clinical fellowship year are to be supervised in accordance with Chapter 1370-1 Rules for Speech Pathology and Audiology and procedures as set forth by the American Speech-Language-Hearing Association
5. Evidence of the above supervisory requirements must be formally documented and signed and dated by both the staff member and supervisor.
6. Further specifics of requirement regarding supervision of licensed practical nurses can be found in the Rules and Regulations of Licensed Practical Nurses, Chapter 1000-2 and the Rules and Regulations of Registered Nurses, Chapter 1000-1.

1200-8-34-.04 Administration
(15) Human Immunodeficiency Virus (HIV) Exposure
1200-8-34-.06 Basic Agency Functions
(7d) Human Immunodeficiency Virus (HIV) Exposure

A. Policy
Agency staff will report potential exposures to HIV infection and any other identified causative agent of acquired immune deficiency syndrome and will be provided with procedures for post exposure follow-up for both themselves and the consumer.

B. Objectives
1. To provide consumers and staff with a system of follow-up if exposure occurs.

2. To promote a safe, healthy working environment.

3. To identify the agency's approach to the care of consumers and personnel issues related to HIV.

C. Definitions
1. Human T-Lymphotropic Virus type III (HTLV-III), referred to as HIV, is a virus that infects the cells of the T-lymphocyte system. The virus can lead to the disease-related complex known as AIDS, which destroys the immune system, leaving the body vulnerable to a variety of opportunistic diseases.
2. HIV can be transmitted by sexual contact, needle sharing, transfusions of blood or blood products, and perinatally from an infected mother to neonate. There is no evidence that casual contact leads to transmission.

D. Procedures
1. **The reference, *Infection Control Overview and Guidelines,* and other reference material/training deemed appropriate should be used in orienting agency staff to standard precautions in preventing exposures.**
2. **If a staff member incurs exposure it is to be reported to their supervisor.**
3. **Written documentation of the route of exposure and the circumstances related to the incident as soon as feasible following the exposure. This is to be given to the supervisor.**
4. **The agency will inform the source individual (consumer) and request that they be tested for HIV infection at their local health department in order to determine their status.**
5. **All staff members who incur an exposure will be offered post exposure evaluation and follow-up in accordance with the OSHA standards.**

The agency should refer to the OSHA website when developing their procedures, for Federal Standards (specifically the Bloodborne Pathogens Standard, codified as 29 CFR 1910.1030) at http://www.osha.gov/. The agency may also choose to address in their policy issues such as confidentiality, employees refusing to work with a consumer known to have HIV or AIDS, any restrictions of employees from working with a consumer known to have HIV or AIDS, and how they will handle situations where their staff are discovered to have HIV or AIDS)

1200-8-34-.04 Administration
(16) Non-retaliation

A. Policy
No agency or staff member shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith against the agency or a staff member of the agency.

B. Objectives
1. To protect consumers from retaliation of the agency or an agency staff member serving them.
2. To hold agencies accountable for the services they are paid to provide to consumers.
3. To promote an environment of non-discrimination.

C. Procedure
1. Staff members are oriented to the fact that any person can contact the Department of Health, the Department of Human Services Adult Protective Services, or the Comptroller of the State Treasury to make a complaint about the services offered by an agency.
2. An agency shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.
3. The agency shall not retaliate against its staff if they are involved in any of the aspects of a complaint as noted above.
4. The agency or its staff shall not retaliate against any person making a complaint.

1200-8-34-.05 Admissions, Discharges, and Transfers

A. Policy
The agency will provide professional support services as prescribed by the attending physician and follow discharge procedures as set forth by the Provider Agreement with the Division of Mental Retardation Services and TennCare.

B. Objectives
1. To ensure services are provided under the care of a physician.
2. To ensure that agencies do not discriminate against consumers.
3. To ensure consumer discharges are in compliance with DMRS/TennCare regulations per the provider agreement.
4. To ensure that services are not discontinued prior to another agency being in place, if the consumer still needs those services.
5. To ensure that an agency appropriately recommends discharging a consumer when expected outcomes are reached and no additional needs are identified.

C. Procedures for Admissions
1. The agency shall accept consumer referrals for professional support services on the basis of a reasonable expectation that the consumer's nursing and therapy needs can be met adequately by the agency.
2. The agency staff shall obtain the consumer or his/her designee's written consent for professional support services.
3. The signed consent form shall be included with the consumer's medical record.
4. The agency staff shall determine, through evaluation, if the consumer's needs can be met by the agency's services and capabilities.
5. Professional support services shall be provided as prescribed by the consumer's attending physician (who holds a license in good standing, as defined in this chapter).
6. The plan for providing professional support services and the expected outcomes shall be reflected in the consumer's plan of care and incorporated into the individual support plan.
7. No medication or treatment shall be provided to any consumer of an agency except on the order of a physician lawfully authorized to give such an order.

D. Procedures for Discharges
1. Proposed discharges based on the accomplishment of outcomes and no identification of additional needs based on a reassessment shall be documented.
2. A reassessment will be completed prior to a recommended discharge.
3. Services provided, progress made during the time services were provided, outcomes met, reasons for the discharge, and status at the time of discharge shall be included in the above documentation.
4. Proposed discharges based on the accomplishment of outcomes should be discussed with the consumer and his/her circle of support.
5. For other discharges initiated by the agency, prior to discontinuation of authorized services, the agency will obtain approval from the DMRS.
6. The agency will notify the consumer, their conservator or guardian, the support coordinator, and DMRS no less than sixty (60) days prior to the planned discharge.

7. If the consumer or his/her representative request a hearing in accordance with T.C.A. 33-1-202, the discharge will not occur prior to the final agency decision and resolution of the administrative appeal unless ordered by a court and approved by the state.
8. The agency shall continue to provide services until the consumer is provided with other services that are of acceptable and appropriate quality in order to maintain continuity of care.
9. If the consumer or his/her representative request to be discharged from the agency, the agency will follow the steps as outlined above and provide transfer documentation to new provider, if requested, in order to maintain continuity of care and facilitate transfer.

1200-8-34-.06 Basic Agency Functions
(1-5) General, Nursing, and Therapy services

A. Policy

The agency will provide professional support services as prescribed by the attending physician, with a plan of care written in coordination with other services being provided to the consumer.

B. Objective

To ensure services are integrated and based on functional outcomes.

C. General Procedures

1. All personnel providing professional support services shall assure that their efforts effectively complement other services provided to the consumer, are functionally integrated into the individual daily routine and support the outcome outlined in the individual support plan.
2. A written report of progress shall be provided to the consumer's support coordinator/case manager monthly.
3. A written summary report for each patient shall be sent to the attending physician at least annually.
4. The written plan of care, developed in consultation with other disciplines supporting the consumer, shall cover all pertinent diagnoses, including:
   - mental status
   - types of services and equipment required
   - frequency of services
   - prognosis
   - rehabilitation potential (as applicable)
   - functional limitations
   - activities permitted
   - nutritional requirements
   - medications and treatments
   - any safety measures to protect against injury
   - instructions for timely discharge or referral

     any other appropriate items
5. A copy of this plan shall be provided to the Consumer's Individual Support Coordinator to be incorporated into the Individual Support Plan.
6. If a physician refers a consumer under a plan of care, which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for professional support services shall include the specific treatment or modalities to be used and the amount, frequency and duration. The therapist and other organization personnel shall participate in developing the plan of care.
7. The plan(s) of care for acute or episodic illness shall be reviewed by the attending physician and agency personnel involved in the consumer's care as often as the severity of the patient's condition requires, but at least annually. Plans of care resulting from Comprehensive Nursing Assessment will be reviewed in accordance with the physical status review schedule. Evidence of review by the physician must include the physician's signature and date of the review on the plan of care. A facsimile of the physician's signature is acceptable.

Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

8. Drugs and treatments shall be administered by appropriately licensed agency personnel, acting within the scope of their licenses. Orders for drugs and treatments shall be signed and dated by the physician.

D. Skilled Nursing Services Procedures
   1. When skilled nursing is provided, the services shall be provided by or under the supervision of a registered nurse who has no current disciplinary action against his/her license, in accordance with the plan of care. This person shall be available at all times during operating hours and participate in all activities relevant to the professional support services provided, including the development of qualifications and assignment of personnel.
   2. The registered nurse's duties shall include but are not limited to the following: make the initial evaluation visit, except in those circumstances where the physician has ordered therapy services as the only skilled service; regularly evaluate the patient's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the physician and other personnel of changes in the patient's condition and needs; counsel the patient and family in meeting nursing and related needs; participate in in-service programs; supervise and teach other nursing personnel. The registered nurse or appropriate agency staff shall initially and periodically evaluate drug interactions, duplicative drug therapy and non-compliance to drug therapy.
   3. The licensed practical nurse shall provide services in accordance with agency policies, which may include but are not limited to the following: prepare clinical and progress notes; assist the physician and/or registered nurse in performing specialized procedures; prepare equipment and materials for treatments; observe aseptic technique as required; and assist the patient in learning appropriate self-care techniques.

E. Therapy Services Procedures
   1. All therapy services offered by the agency directly or under arrangement shall be planned, delegated, supervised or provided by a qualified therapist in accordance with the plan of care. A qualified therapist assistant may provide therapy services under the supervision of a qualified therapist in accordance with the plan of care. The therapist shall assist the physician in evaluating the level of function, helping develop the plan of care (revising as necessary), preparing clinical and progress notes, advising and consulting with the family and other agency personnel, and participating in in-service programs.
   2. Speech therapy services shall be provided only by a licensed speech language pathologist in good standing or therapist in the Clinical Fellowship Year under the supervision of a licensed speech language pathologist.

1200-8-34-.06 Basic Agency Functions
(6) Performance Improvement

A. Policy
An agency will conduct an internal performance review of its professional support services at least annually.

B. Objectives
1. To assist the agency in using its personnel and facilities to meet individual and community needs.
2. To identify and correct deficiencies that undermine quality of care and lead to waste of agency and personnel resources.
3. To help the agency make critical judgments regarding the quality and quantity of its services through self-examination.
4. To provide opportunities to evaluate the effectiveness of agency policies and when necessary make recommendations to the administration as to controls or changes needed to assure high standards of patient care.
5. To augment in-service staff education, when applicable.
6. To provide data needed to satisfy state licensure and certification requirements.
7. To establish criteria to measure the effectiveness and efficiency of the professional support services provided to consumers.
8. To develop a record review system for the agency to evaluate the necessity or appropriateness of the professional support services provided and their effectiveness and efficiency.

C. Procedures
1. An agency shall have a committee or mechanism in place to review, at least annually, past and present professional support services including contract services, in accordance with a written plan, to determine their appropriateness and effectiveness and to ascertain that professional policies are followed in providing these services. ***(For a one-person agency, the mechanism for this can be the DMRS Quality Enhancement annual survey)***
2. The agency will formally document this review process and maintain it on file for review by the Division of Mental Retardation and the Department of Health.

1200-8-34-.06 Basic Agency Functions
(7) Infection Control

A. Policy
The agency must have in place a program that addresses the prevention, control and investigation of infections and communicable diseases.

B. Objectives

1. To provide and maintain a safe working and social environment.

2. To ensure that the risk of infection is kept to a minimum.

3. To provide a non-discriminatory environment that supports people living with infectious disease.

C. Procedures
1. Universal precautions involves the use of protective barriers and practices to protect employees from exposure to infectious agents via puncture of the skin, contact with mucous membranes, saliva and non-intact skin. Mucous Membranes include the lining of the mouth, nose and respiratory tract, the conjunctival membrane covering the eye, the gastrointestinal tract, and the urinogenital tract. Universal Precautions will be observed in order to prevent contact with blood, blood products, or other potentially infectious materials. All blood, blood product, or other potentially infectious material will be considered infectious regardless of the perceived status of the source or source individual.

2. Hands must be washed after contact with blood or body fluids, before eating or drinking. Routine hand washing is paramount when there is any routine physical contact with people and particularly important when there has been contact with blood or body fluids.

3. The wearing of gloves substantially reduces the risk of hands being contaminated with blood and body fluids and therefore gloves must be readily available to all employees likely to handle blood or body substances.

4. After proper removal and disposal of personal protective gloves or other personal protective equipment, employees shall wash their hands and any other potential contaminated skin area immediately or soon as feasible with soap and water.

5. Gloves contaminated with blood or body fluids should be discarded between treating persons - the wearing of gloves does not prevent cross-infection.

6. Hands should be thoroughly washed after discarding gloves.

7. If staff members incur exposure to their skin or mucous membranes, then those areas shall be washed or flushed with water as appropriated or as soon as feasible following contact.

8. Precautions shall be taken to prevent the contamination of sterile and clean supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents.

9. At the time of orientation, all staff will be informed of the Infection Control Policy and Procedures and will be provided a copy.

10. Education on infection control, including cause, effect, transmission, prevention, and elimination of infections will be made available by the agency as a part of the orientation process as evidenced by staff being able to verbalize or demonstrate an understanding of basic techniques (see attached reference entitled *Infection Control Overview and Guidelines*)

11. Appropriate staff and/or consumers, their family and/or their support staff will be educated in the practice of aseptic techniques such as handwashing and scrubbing practices, proper hygiene, use of personal equipment, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of consumer care equipment and supplies.

Infection Control Overview and Guidelines

Section I: Overview

Many conditions and invasive procedures predispose individuals to infection either because the integrity of the skin or mucous membrane is altered or because an illness reduces the body's ability to summon additional defenses adequately against other invading microorganisms. Individuals with surgical incisions, artificial airways, catheters, intravenous lines, or implanted prosthetic devices, and those who continually have the skin broken by needle sticks for injections or the drawing of blood samples are at greater risk for infection and must be protected.

Infection control by methods of medical asepsis and universal precautions is a major factor in preventing the spread of infection. The other method of preventing the spread of infection is by the use of isolation procedures.

Infection control involves surveillance for signs of infection, immediate procedures to contain microorganisms when infection is evident, proper handling, sterilization or disposal of contaminated items and equipment, protection of individuals at high risk for infection, and prevention of nosocomial infections.

Infection control depends on knowing the mechanisms by which an infectious disease is transmitted and the methods that will interfere with the infectious process cycle. The single most important means of preventing the spread of infection is frequent hand washing. The process of increasing an individual's resistance to a particular infection by artificial means is called immunization.

Anticipated Outcomes of Infection Control

1. Infection does not spread to other body parts.
2. Proper handwashing.
3. Appropriate use of personal protective equipment.
4. Specific precautions for handling infectious material and sharps.
5. Procedures for routine disinfection of environmental surfaces and spills.

Section II: Course of infection:

An infection is a condition that results when microorganisms cause injury to their host. At one time contagious diseases, also called infectious or communicable diseases because they are spread from one person to another, were the leading cause of death. But because of the development of vaccines, implementation of aggressive public health measures, and advances in drug therapy, that is no longer the case. Nevertheless, contagious diseases have not disappeared.

Infections progress through distinct stages. The characteristics and lengths of each stage may differ depending on the infectious agent. Infection control depends on

knowing the mechanisms by which an infectious disease is transmitted and the methods that will interfere with the infections process cycle.

Incubation Period

There is an interval between entrance of the pathogen into the body and appearance of first symptoms (e.g., chicken pox 2 to 3 weeks, common cold 1 to 2 days, influenza 1 to 3 days, and mumps 18 days). The infectious agent reproduces, but there are no recognizable symptoms. The infectious agent may, however, exit the host at this time and infect others.

Prodromal Stage of Illness

Initial symptoms that appear may be vague and nonspecific. There is an interval from the onset of nonspecific signs and symptoms (malaise, low-grade fever, and fatigue) to more specific symptoms; during this time, microorganisms grow and multiply. An individual is more capable of spreading disease to others.

Full Stage of Illness (Acute Stage)

Symptoms become severe and specific to the tissue or organ affected. The individual manifests signs and symptoms specific to type of infection (e.g., common cold manifested by sore throat, sinus congestion, and rhinitis. Mumps manifested by earache, high fever, parotid and salivary gland swelling. Tuberculosis is manifested by respiratory symptoms).

Convalescence

Acute symptoms of infection disappear; length of recovery depends on severity of infection and individual's general state of health; recovery may take several days to months. Health improves or is restored.

Section III: Defenses against infection:

A. Normal defenses

The body has normal defenses against infection. Normal flora, body system defenses, and inflammation are nonspecific defenses that protect against microorganisms, regardless of prior exposure. The immune system is composed of separate cells and molecules, some of which fight specific pathogens.

Normal Flora

The body normally contains large numbers of microorganisms that reside on the surface and deep layers of the skin, in saliva and oral mucosa, and in the intestinal walls. Normal flora does not cause disease but instead help to maintain health. The number of flora maintains a sensitive balance with other microorganisms to prevent infection. Any factor that disrupts this balance places an individual at serious risk for infection.

Body System Defenses

The skin, respiratory tract, and gastrointestinal tract are easily accessible to microorganisms, but they also have unique defenses against infection, physiologically suited to their structure and function. Any conditions that impair an organ's specialized defenses increase susceptibility to infection.

Inflammation

The body's cellular response to injury or infection is inflammation. Inflammation is a protective vascular reaction that delivers fluid, blood products, and nutrients to interstitial tissues in an area of injury. The process neutralizes and eliminates pathogens or neurotic tissues and establishes a means of repairing body cells and tissues. Signs of inflammation include swelling, redness, heat, pain or tenderness, and loss of function in the affected body part. When inflammation becomes systemic, other signs and symptoms develop; these include fever, leukocytosis, malaise, anorexia, nausea, vomiting, and lymph node enlargement.

Immune Response

When a foreign material (antigen) enters the body, a series of responses change the body's biological makeup so that reactions to future antigens are different from the first in an immune response, the antigen is neutralized, destroyed, or eliminated.

B. Types of precautions

Infection control refers to physical measures that attempt to curtail the spread of infectious or contagious diseases. The Center for Disease Control and Prevention (CDC) drafted outlining two major categories for infection control. They include Standard Precautions and Transmission-Based Precautions.

Standard Precautions are used when caring for all individuals regardless of their infection status. Standard Precautions reduce the potential for transmitting blood-borne pathogens and those from moist body substances like feces, urine, sputum, saliva, wound drainage and other body fluids. They are followed whenever there is the potential for contact with: blood; all body fluids, secretions and excretions, regardless of whether they contain visible blood; non-intact skin; mucous membranes. They include Universal Precautions and Body Substance Isolation.

Transmission-Based Precautions, also called isolation precautions, are measures that are recommended for use in addition to Standard Precautions. Their purpose is to control the spread of infectious agents from persons with known or suspected transmissible pathogens. These include airborne precautions, droplet precautions, and contact precautions. These replace the previous categories of Strict Isolation, Contact Isolation, Respiratory Isolation, Enteric Precautions, and Drainage/Secretion Precautions. Transmission-Based Precautions may be required for various lengths of time depending on the nature of the infecting microorganism.

C. Universal precautions

Health care workers are to wash their hands for 15-30 seconds using accepted facility procedures before and after each direct contact with an individual or the person's care items. Soap used should be from a dispenser or sponge scrub pad; bar soap is not acceptable. Handwashing is to be performed before donning gloves and after removing them. The sink, faucets, and paper towel dispenser are contaminated and should not be touched after handwashing. Only disposable towels

are used for routine handwashing. Use a paper towel to turn off the water. If the towel dispenser requires that a crank be used to obtain the towel, dispense the towel prior to washing hands. Use a paper towel to open the exit door if needed. Dispose of used paper towels directly into the trash.

Handwashing is a vigorous, brief rubbing together of all surfaces of lathered hands, followed by rinsing under a stream of water. Push wristwatch and long sleeves above the wrists. Remove jewelry, except plain band, from fingers and arms. Keep fingernails short filed, and free of nail polish or artificial fingernails. Inspect surface of hands and fingers for breaks or cuts in skin and cuticles. Stand in front of sink, keeping hands and clothing away from sink surface. Avoid splashing water against clothing. Regulate flow of water so that temperature is warm. Hot water opens pores of the skin, causing irritation. Wet hands and lower arms thoroughly under running water. Keep hands and forearms lower than elbows during washing. Wash hands using plenty of lather and friction. Interlace fingers and rub palms and back of hands with circular motion at least 5 times each. Clean areas underlying fingernails. Rinse hands and wrists thoroughly, keeping hands down and elbows up. Repeat washing process if hands or nails are not clean. Dry hands thoroughly from fingers to wrists and forearms. Discard paper towel in proper receptacle. Turn off water using clean, dry paper towel.

D. Personal protective equipment

Gloves
Wear clean gloves when touching; blood, body fluids, secretions, excretions, and items containing these body substances; mucous membranes; non-intact skin. Follow facility policy.

Gowns
Non-permeable gowns are to be worn when it is anticipated that the clothing may become soiled with blood or body fluids, including secretions and excretions. Gowns open in the back and fasten at the neck and waist. Follow facility policy.

Masks, Eye protection, Face shield
Wear a mask, eye protection, face shield during procedures and individual care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Follow facility policy.

E. Sharps disposal

Sharp instruments (sharps) are placed directly into a special disposal container immediately after use. These containers shall be puncture resistant, labeled or color-coded, and leak proof on the sides and bottom. The sharp item should be dropped into the opening, and the fingers should never enter the mouth of the container. Never use fingers to push items down into a sharps container. Do not recap used needles. Never leave used, exposed IV needles hanging on the IV pole. All needles, IV cannulas, and items that are sharp or might cause a skin break are placed in the sharps container. Sharps containers should be replaced when they are three quarters full. Follow facility policy.

Section IV: When contamination occurs:

If blood or body fluids should come in contact with the nurse's body, follow facility policy and procedures to reduce contamination. The following are some suggestions.

Hands: Wash thoroughly with soap and water; use antimicrobial soap if available. Rinse or wipe with 70% isopropyl alcohol or a povidone-iodine solution after washing. If broken skin was involved, report to the employee health center or emergency room. An injury report must be completed when broken skin is involved.

Eyes: Flush immediately with large amounts of cool water. Report immediately to the employee health center or emergency room. An injury report must be completed.

Mouth or other mucous membranes: Rinse immediately with large amounts of water. Report to the employee health center or emergency room. An injury report is required.

Clothing: When clothing has become soiled by blood or body fluids, remove them and place them in a plastic bag for transport. Using gloves, treat bloodstains with cold water and stain remover, and then wash the items in the hot cycle with detergent. Use chlorine bleach if appropriate for the material. Clothing may also be dry cleaned but allow it to air out for 3 days so that viral agents will die before the clothing is taken to the dry cleaner.

Blood and body fluid spills: Spills are to be wiped up, using heavy gloves, with a freshly prepared 1:10 solution of chlorine bleach. A one-minute contact time is necessary to kill HIV and other viruses. Know the correct solution to use for various spills or call the facility environmental health worker.

Nursing equipment: Wipe pens with alcohol swabs daily. Expose the blood pressure cuff to several hours of sunlight at least once a week; wash the cuff once a month or expose it to sunlight for a full 8 hours. Use only disposable covers on thermometers and otoscopes. Clean stethoscope, sphygmomanometer, or other equipment after use on individual so pathogens are not transferred to the next individual.

Section V: Disposing of contaminated materials:

Various receptacles are used to hold and collect contaminated items. Soiled waste containers are emptied at the end of each shift or more often if their contents accumulate. To avoid spreading pathogens, some items are double-bagged. Follow existing facility policies.

Biodegradable trash is that which will decompose naturally into less complex compounds. Some items like uneaten food, paper tissues, the contents of drainage collectors, urine, and stool may be flushed down the toilet. Chemicals and filtration methods in sewage treatment centers are sufficient for destroying pathogens in human wastes.

Moist items such as soiled dressings, however, are wrapped so that during their containment flying or crawling insects cannot transfer pathogens. In some facilities, eventually the bag and its contents are destroyed by incineration, or they are autoclaved. Autoclaved items may be safely disposed of in landfills. In the home the soiled materials are to be placed in a small plastic bag, secured, then placed in the trash receptacle with a tight fitting lid for collection.

Section VI: Specimen collection techniques:

Follow facility policy and procedure regarding specimen collection and documentation. Nurses apply gloves when there is a risk of exposure to potentially infectious material. Specimens are delivered to the laboratory in sealed containers. The facility's infection control guidelines are followed as to whether the sealed containers are additionally bagged. When the testing is complete, most specimens are flushed, incinerated, or sterilized. Some suggestions for the collection of specimens may include:

Wound Specimen
Use cotton-tipped swab or syringe to collect as much drainage as possible. Have clean test tube or culturette tube on clean paper towel. After swabbing center of wound site, grasp collection tube by holding it with paper towel. Carefully insert swab without touching outside of tube. After securing tube's top, transfer into bag for transport and then wash hands.

Blood Culture Specimen
Use syringe and culture media bottles to collect 10 ml of blood per culture bottle. Perform venipuncture at two different sites to decrease likelihood of both specimens being contaminated with skin flora. Place blood culture bottles on bedside table or other surface, swab off bottletops with alcohol. Inject appropriate amount of blood into each bottle. Remove gloves and transfer specimen into clean bag for transport.

Stool Specimen
Use clean cup with seal top (not necessary to be sterile) and tongue blade to collect small amount of stool, approximately the size of a walnut. Place cup on clean paper towel in bathroom. Using tongue blade, collect needed amount of feces from the bedpan (if used). May also collect directly from the toilet if allowed by order of physician or laboratory. Transfer feces to cup without touching cups outside surface. Dispose of tongue blade, wash hands, and place seal on cup. Transfer specimen into clean bag for transport.

Urine Specimen
Use syringe and sterile cup to collect 1-5 ml of urine. Place cup or tube on clean towel in bathroom. Use syringe to collect specimen if individual has a Foley catheter. Have the individual follow procedure to obtain a clean voided specimen if not catheterized. Transfer urine into sterile container by injecting urine from syringe or pouring it from used container. Wash hands and secure top of container. Transfer specimen into clean bag for transport.

Section VII. Documentation and teaching:

Charting for the individual with problems of infection control should include noting the assessment date regarding the signs of infection and checking on flow sheets the type of isolation procedures used each shift. Include the data regarding the course of the infection, the individual's response to the medical therapy for the infection, and any measures used to protect the individual from nosocomial infection.

Airborne Precautions are measures used to block very small pathogens that remain suspended in the air or are attached to dust particles. Droplet Precautions are measures used to block larger pathogens contained within moist droplets. Contact Precautions are used to block the transmission of pathogens by direct or indirect contact.

To prevent infections, the nurse can recommend that people (1) obtain appropriate immunizations, (2) practice a healthy lifestyle, and (3) avoid sharing personal care items. Unfortunately, symptoms of infectious disorders tend to be more subtle among older adults and individuals with chronic conditions.

1200-8-34-.06 Basic Agency Functions
(8) Medical Records

A. Policy
A medical record shall be developed and maintained for each consumer admitted.

B. Objectives
1. To maintain required documentation.
2. To note progress towards outcomes.
3. To facilitate integration of services.

C. Procedures
1. A medical record containing past and current findings in accordance with accepted professional standards will be maintained for every consumer receiving professional support services.
2. In addition to the plan of care, the record shall contain:
   - appropriate identifying information
   - the consumer's or his/her designee's written consent for professional support services
   - name of physician
   - a diagnosis
   - all medications and treatments
   - plan of care/recommendations based on assessment
   - outcomes in the individualized support plan
   - signed and dated clinical notes
3. Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.
4. All medical records, either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of consumers under mental disability or minority, their complete agency records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the consumer, whichever is longer.
5. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the agency's policies and procedures, and no record may be destroyed on an individual basis.
6. Even if the agency discontinues operations, records shall be maintained as mandated by this chapter and the Tennessee Medical Records Act (T.C.A. §§ 68-11-308). If a consumer is transferred to another health care facility or agency, a copy of the record or an abstract shall accompany the consumer when the agency is directly involved in the transfer.
7. Medical records information shall be safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. The consumer's written consent shall be required for release of information when the release is not otherwise authorized by law.

8. For purposes of this rule, the requirements for signature or countersignature by a physician or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established protocol or rules.
9. Records shall be available for review by the Department of Health and the Division of Mental Retardation Services.

1200-8-34-.10 Infectious and Hazardous Waste

A. Policy
Each agency shall develop, maintain and implement a system for defining and handling its infectious and hazardous waste and which complies with the standards of other applicable state and federal regulations.

B. Objective

To assure proper disposal of normal and hazardous waste and needles.

C. Procedures
1. The following waste shall be considered to be infectious waste:

(a) Waste human blood and blood products such as serum, plasma, and other blood components;

(b) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in patient care; and

(c) Other waste determined to be infectious by the agency in its written policy.

2. Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid and puncture-resistant containers, which must then be tightly sealed.

(b) Infectious and hazardous waste must be secured in fastened plastic bags before placement in a garbage can with other household waste.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

3. After packaging, waste must be handled, transported and stored by methods ensuring containment and preserving of the integrity of the packaging, including the use of secondary containment where necessary.

4. Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons. Waste must be stored in a manner and location which affords protection from animals, precipitation, wind

and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.

5. In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the agency must ensure that proper actions are immediately taken to:

   (a) Isolate the area;

   (b) Repackage all spilled waste and contaminated debris in accordance with the requirements of this rule; and,

   (c) Sanitize all contaminated equipment and surfaces appropriately.

1200-8-34-.11 Records and Reports
(2) Unusual Events

A. Policy
The agency must have a system of reporting unusual events (as defined by the Department of Health) to the Department of Health (DOH).

(Note: Agencies must also adhere to the DMRS Operating Guideline 4.02, Incident Reporting and Notification)

B. Objective
1. To inform appropriate entities outside of the agency of an unusual event.
2. To ensure that appropriate follow-up occurs.
3. To promote the development of systems within the agency to avoid further occurrences of similar unusual incidences.

C. Procedures
1. Unusual events shall be reported by the facility (also referred to as the agency) to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a consumer or an unexpected occurrence or accident that results in death, life threatening or serious injury to a consumer. ***(refer to the DOH website http://www.state.tn.us/health/ and click on Health Care Licensure and Regulation, Health Care Facilities, and Unusual Incident Reporting System, to obtain a form)***

2. For health services provided in a "home" setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

3. The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a consumer, not related to a natural course of the consumer's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

   a) medication errors that result in permanent consumer injury, a near death event, or a death ***(note: there is an additional one-page reporting form called the Medication Occurance Form that must be submitted with the Unusual Event Report Form)***

   b) aspiration in a non-intubated consumer related to conscious/moderate sedation;

   c) intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

   d) volume overload leading to pulmonary edema;

   e) blood transfusion reactions, resulting in death or use of wrong type of blood and/or delivery of blood to the wrong consumer;

f) perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness or death;

g) burns of a second or third degree;

h) falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

i) procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

1. procedure related injury requiring repair or removal of an organ
2. hemorrhage that results in serious injury or death
3. displacement, migration or breakage of an implant, device, graft or drain
4. post operative wound infection following clean or clean/contaminated case
5. any unexpected operation or reoperation related to the primary procedure
6. hysterectomy in a pregnant woman
7. ruptured uterus
8. circumcision requiring repair
9. incorrect procedure or incorrect treatment that is invasive
10. wrong patient/wrong site surgical procedure
11. unintentionally retained foreign body
12. loss of limb or organ, impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence
13. criminal acts
14. suicide or attempted suicide
15. elopement from the facility
16. infant abduction, or infant discharged to the wrong family
17. adult abduction
18. rape
19. consumer altercation
20. abuse, neglect, or misappropriation of consumer funds
21. restraint related incidents
22. poisoning occurring within the facility.

4. Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

a.) strike by the staff at the facility
b.) external disaster impacting the facility
c.) disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel

d.) fires at the facility which disrupt the provision of consumer care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

5. Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department (see attached DOH form). The department's approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or casual factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

6. The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

7. The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

8. The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

9. The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the

examples set forth above in (3) and (4). If an event or specific incident fails to come within these examples, it shall be classified as “other” with the facility explaining the facts related to the event or incident.

10. This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

11. The affected patient and/or the patient’s family, as may be appropriate, shall also be notified of the incident by the facility.

12. During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of incidents reported by facilities to the Department for the preceding calendar year.

13. The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

1200-8-34-.12 Consumer Rights

A. Policy
The agency shall ensure that its staff support consumer rights.

B. Objective
To ensure that consumers rights are adhered to.

C. Procedures
1. Each consumer has at least the following rights:

    a) To privacy in treatment and personal care;

    b) To have appropriate assessment and management of pain.

    c) To be involved in the decision making and all aspects of their care.

    d) To be free from mental and physical abuse. Should this right be violated, the agency must notify the Department of Health within five (5) business days, the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. §71-6-101 et seq. (This requirement for DOH PSS license does not release the agency from the responsibilities of reporting incidents to the Division of Mental Retardation as outlined in the Operating Guideline 4.02, Incident Reporting and Notification)

    e) To refuse treatment. The consumer must be informed of the consequences of that decision, and the refusal and its reason must be reported to the physician and documented in the medical record;

    f) To refuse experimental treatment and drugs. The consumer's written consent for participation in research must be obtained and retained in his or her medical record; and

    g) To have his or her records kept confidential and private. Written consent by the consumer must be obtained prior to release of information except to persons authorized by law. If the consumer is mentally incompetent, written consent is required from the consumer's legal representative. The agency must have policies to govern access and duplication of the consumer's record.

2. Each consumer has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.